

Wisconsin Department of Safety and Professional Services

Mail To: P.O. Box 8935
Madison, WI 53708-8935
FAX #: (608) 261-7083
Phone #: (608) 266-2112

1400 E. Washington Avenue
Madison, WI 53703
E-Mail: dsps@wisconsin.gov
Website: <http://dsps.wi.gov>

PHARMACY EXAMINING BOARD

HOME MEDICAL OXYGEN PROVIDER ACCREDITING ORGANIZATIONS

In order to obtain a Home Medical Oxygen Provider license you need to be accredited by one of the following organizations:

Accrediting Organization (AO)	Contact Information
Accreditation Commission for Health Care, Inc. (ACHC)	139 Weston Oaks Court Cary, NC 27513 (855) 937-2242 http://www.achc.org
American Board for Certification in Orthotics, Prosthetics and Pedorthics, Inc. (ABC)	330 John Carlyle Street, Suite 210 Alexandria, VA 22314 (703) 836-7114 http://www.abcop.org
Board of Certification/Accreditation (BOC)	10451 Mill Run Circle, Suite 200 Owings Mills, MD 21117 (877) 776-2200 http://www.bocusa.org
Commission on Accreditation of Rehabilitation Facilities (CARF)	6951 E. Southpoint Road Tucson, AZ 85756 (888) 281-6531 http://www.carf.org/dmepos
Community Health Accreditation Program, Inc. (CHAP, Inc.)	1275 K Street, NW, Suite 800 Washington, DC 20005 (202) 862-3413 http://www.chapinc.org
Healthcare Quality Association on Accreditation (HQAA)	114 East 4th Street, Suite 200 Waterloo, IA 50703 or P.O. Box 1948 Waterloo, IA 50704 (866) 909-4722 http://www.hqaa.org
National Association of Boards of Pharmacy (NABP)	1600 Feehanville Drive Mount Prospect, IL 60056 (847) 391-4406 http://www.nabp.net
The Compliance Team, Inc.	P.O. Box 160 905 Sheble Lane, Suite 102 Spring House, PA 19477 (215) 654-9110 http://www.thecomplianceteam.org
The Joint Commission	One Renaissance Boulevard Oakbrook Terrace, IL 60181 (630) 792-5800 http://www.jointcommission.org
The National Board of Accreditation for Orthotic Suppliers (NBAOS)	15000 Commerce Parkway, Suite C Mount Laurel, NJ 08054 (856) 380-6856 http://www.nbaos.org

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HOME MEDICAL OXYGEN PROVIDER APPLICATION

PLEASE TYPE OR PRINT IN INK

☐ Your name and address are available to the public.
☐ Check box to withhold street address/PO Box number from lists of 10 or more credential holders (Wis. Stat. § 440.14)

☐ NEW PROVIDER

☐ CHANGE OF OWNERSHIP

☐ CHANGE OF LOCATION

For change of ownership or location please provide **CURRENT LICENSE NUMBER:** _____ - 48.

FACILITY NAME and FEIN:

DBA: If different from facility name, name or title under which business is operated. (This must be the name on the provider label.)

DAYTIME TELEPHONE NUMBER:

FAX NUMBER:

FACILITY ADDRESS: number, street, city, zip code

MAILING ADDRESS UNTIL DAY OF OPENING (if applicable): number, street, city, zip code

EMAIL ADDRESS:

NAME OF OWNER OR NAMES AND TITLES OF ALL PARTNERS, CORPORATE OFFICERS AND SHAREHOLDERS OWNING ABOVE 20% OF VOTING STOCK: (Attach additional sheets if necessary.)

NAME

ADDRESS (City State Zip)

**RPh?
(Y/N)**

APPLICATION FEE: Please make check payable to DSPS and attach to application.

\$75.00 Initial Credential Fee

For Receipting Use Only (48)

Wisconsin Department of Safety and Professional Services

Please answer the following questions:

YES NO

1. Have the principals or applicant ever been charged with a felony or misdemeanor?

☐☐

If yes, please complete Form #2252 and provide details about the crime, including date of conviction penalty, and a copy of the court documents. (Please do not give details on minor traffic charges, but do include information relating to Driving While Intoxicated (DWI) charges.)

2. Have any of the principals or applicant conducted a similar business in any other state?

☐☐

If yes, please indicate license number/state issued below.

3. Has the applicant ever made application for a license to operate a Pharmacy, Drug/Device Manufacturer or Wholesale Distributor of Prescription Drugs? **If yes, was the application denied (and for what reason)?**

☐☐

4. Applicant proposes to sell medical oxygen to (check all that apply):

☐

Nursing homes

☐

Home Health Agencies

☐

Public

☐

Hospitals

☐

Ambulance Services

☐

Other: _____

5. Please list the applicant's Accrediting Organization (AO):

AFFIDAVIT OF APPLICANT

I understand that failure to provide requested information, making any materially false statement and/or giving any materially false information in connection with my application for a credential or for renewal or reinstatement of a credential may result in credential application processing delays; denial, revocation, suspension or limitation of my credential; or any combination thereof; or such other penalties as may be provided by law. I further understand that if I am issued a credential, or renewal or reinstatement thereof, failure to comply with the statutes and/or administrative code provisions of the licensing authority will be cause for disciplinary action.

Signature of Applicant

Date